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Acute Coronary Syndromes

A STATEWIDE SURVEY OF EMERGENCY DEPARTMENT STANDARDS OF CARE FOR ACUTE CORONARY SYNDROMES - VARIABILITY AND OPPORTUNITY FOR ADVANCEMENT

ACC Moderated Poster Contributions
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Background: Emergency Department (ED) Acute Coronary Syndrome (ACS) care impacts morbidity and mortality. Variability in ED care standards for ACS exists. This study describes 2010 ED ACS care standards, with particular emphasis on ST-Elevation Myocardial Infarction (STEMI), that exist in a Southwestern US state.

Methods: The study utilized a standardized telephone survey conducted with all EDs at general medical-surgical and critical access hospitals within state borders. Hospital size ranged from 14 to 928 licensed beds. Telephone calls were directed toward ED nursing directors for these hospitals listed within the medical facility registry compiled by the state's Department of Health. If an ED's nursing director was unreachable, a clinical provider at that ED, self-reporting as knowledgeable with that ED's ACS care standards, provided the survey responses. The survey was designed utilizing an internet-based survey platform. Data was collected in a narrow time interval (November 8, 2010 - December 6, 2010) to minimize effect of revisions in care standards.

Results: 132 hospitals met survey contact criteria, with 27 subsequently excluded when reporting ACS patients were not treated at the contacted facility. These were predominantly surgical specialty hospitals. Responses were collected from 105 of the remaining 105 EDs (100% applicable survey population captured). Among several inquiry variables, all 105 EDs reported the use of an ACS or equivalent treatment pathway. Among these 105 EDs, 105 (100%) report staffing registered nurses and 68 (64.7%) report staffing physicians 24 hours per day. Only 19 (18.1%) report the ability to receive a 12-lead electrocardiogram (ECG) obtained by emergency medical services (EMS) prior to the patient's arrival. Additionally, only 20 (19.0%) indicated the availability of emergent cardiac catheterization at their hospital.

Conclusion: Variability in ED ACS care standards exists on a statewide basis. Opportunity exists to improve statewide ED ACS standards with implementation of ability to receive 12-lead ECGs obtained by EMS and increased ability to perform therapeutic cardiac catheterizations.